# CITY OF SAN ANTONIO
## ANIMAL BITE EXPOSURE REPORT

4710 State Hwy 151 San Antonio, Texas 78227
Office Phone- 210-207-6667, 210-207-6668/ Fax- 210-207-6678
Hours of Operation: Mon-Fri- 11 AM to 7 PM; Sat- 11 AM to 5 PM; Sun- Closed
www.sanantonio.gov/animalcare / www.saac.net

As required by Texas Administrative Code, Title 25, Part 1, Chapter 97, Subchapter A, Rule 97.3, and in accordance with Sec. 5-126 of the City of San Antonio ordinance the following requested information is required by law to be reported.
PRINT ALL INFORMATION CLEARLY. FAX A COPY OF THIS REPORT TO: Animal Care Services at 210-207-6678 AND The San Antonio Metropolitan Health District at 210-223-5850.

DATE OF INCIDENT: _____/_____/_____TIME: _____ AM/PM
LOCATION (ADDRESS) OF INCIDENT:
_____

INCIDENT OCCURRED: ON PROPERTY ☐ OFF PROPERTY ☐
EXPOSURE: ANIMAL TO HUMAN ☐ ANIMAL TO ANIMAL ☐

### VICTIM INFORMATION

VICTIM'S NAME: _____ PARENTS NAME (IF MINOR): _____
ADDRESS: _____ CITY/STATE/ZIP: _____
PHONE NUMBER: _____ ALTERNATE PHONE NUMBER: _____
DOB: _____/_____/_____ AGE: _____ SEX: M ☐ F ☐ UNKNOWN ☐
INJURED BODY PART:
_____
(HEAD, NECK, ARM, LEG, ETC.)
SEVERITY OF INJURY: MILD ☐ MODERATE ☐ SEVERE ☐
TYPE OF INJURY: PUNCTURE ☐ LACERATION ☐ SCRATCH ☐ OTHER: _____
BRIEF DETAILS OF THE INCIDENT (ATTACH PHOTOS IF POSSIBLE): _____
_____
_____

**OWNER IDENITIFED ☐ (OR) STRAY ☐**

IDENTIFIED OWNER NAME: _____ ADDRESS: _____
PHONE NUMBER: _____ ALTERNATE PHONE NUMBER: _____
ALLEGED BITING ANIMAL DESCRIPTION:
SPECIES & BREED: _____ COLOR & MARKINGS: _____
SEX: M ☐ F ☐ UNKNOWN ☐ PROOF OF CURRENT VACCINATION: YES ☐ NO ☐ UNKNOWN ☐

### CARE PROVIDERS

IF YOU ARE THE CARE PROVIDER PLEASE CHECK ALL APPROPRIATE BOXES BELOW:

1. PATIENT ASSESSMENT INDICATED NO NEED FOR RABIES PEP ☐
2. WOUNDS TREATED ☐
3. POST-EXPOSURE PROPHYLAXIS INITITATED ☐

A. HRIG. DATE: _____ DOSE #_____ LOT#:_____ MANUFACTURER: _____
B. VACCINE. DATE: _____ DOSE #_____ LOT#:_____ MANUFACTURER: _____

NAME OF CARE PROVIDER: _____

PROVIDER'S PHONE NUMBER: _____

### CLINIC OR FACILITY

FORM COMPLETED BY: _____ DATE & TIME: _____
FACILITY: _____ PHONE #: _____ FAX #: _____

Revised Date 3/1/2011